Key Takeaways from Research in India and Implications for UHC

Winnie Yip, PhD

Roadmap for Universal Health Coverage in India

September 23, 2021

HARVARD T.H. CHAN
SCHOOL OF PUBLIC HEALTH

Poor Financial Risk Protection. OOP for Outpatient Care is a Major Driver.

Catastrophic Health Expenditures	Value
Share of households with CHE at 10%	24%
Share of households with CHE at 25%	10%
Share of CHE at 10% due to drugs	65%
Share of CHE at 10% due to hospital spending	22%
CHE at 10% if drug spending eliminated	9%
CHE at 10% if hospital spending eliminated	19%

24% households face catastrophic health expenses, 10% households are impoverished

Spending on drug is a major driver

54% of outpatient visits are in the private sector. Spending on drug from the private sector major contributor to CHE, even for people who seek care at public facilities.

Spending on drugs

Type of care and provider	Share of patients with CHE (using monthly consumption expenditure)	Mean spend per visit (Rupees)	Drug share of OOP	Mean drug OOP (Rupees)	Share purchasing drugs from private sector chemist
Outpatient					
Public (46%)	25%	790	59%	428	72%
Private hospital outpatient departments and solo providers (24%)	38%	1404	67%	754	100%
Private Chemists and other providers (30%)	25%	735	73%	512	98%
Inpatient					
Public (75%)	19%	10,407	41%	3,287	n/a
Private (25%)	52%	33,886	37%	10,380	n/a

Why do people purchase drugs from private chemists? Possible explanations

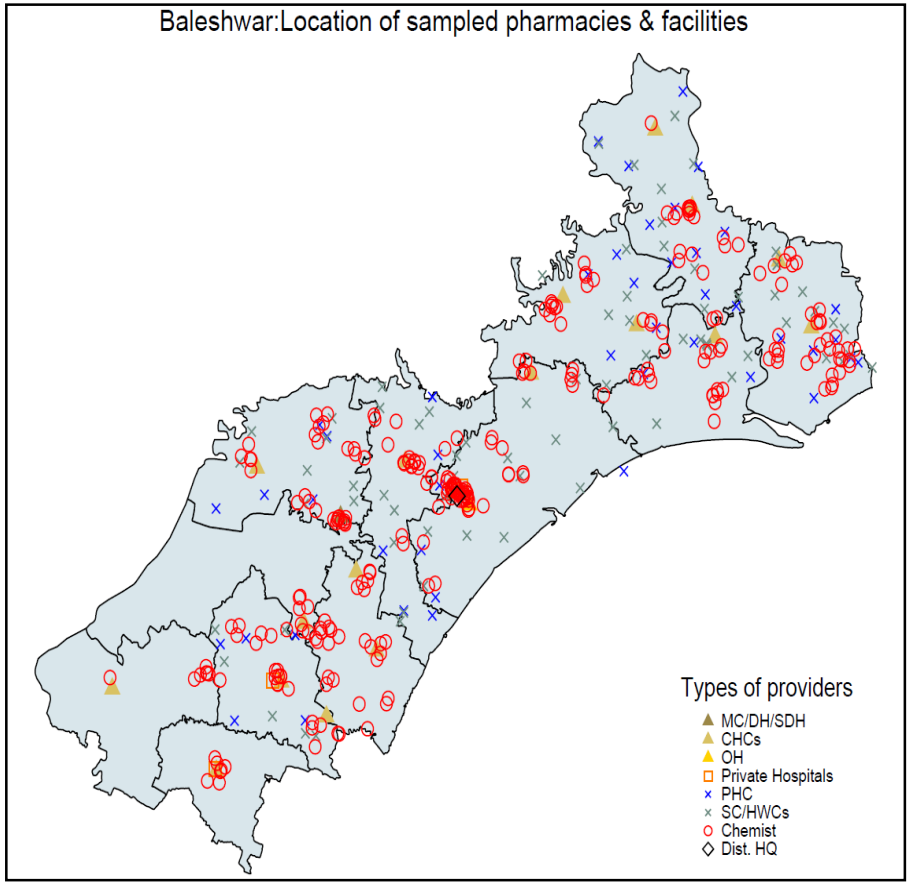
- **Poor supply of drugs, frequent stock-outs at public facilities**. Availability of medicines vary by level of care, with very low availability at primary levels:
  - 73% essential medicines in stock at public hospitals, 59% at private hospitals, 66% at CHCs.
  - 38% at PHCs, 18% at Sub-centers and HWCs, 48% at private chemist shops.

- **Financial interests and incentives for public providers to refer patients to pvt chemists** - through either ownership of the chemist shop or commissions for sales of drugs to referred patients.
  - 15% patients reported that the provider referred them to a specific chemist shop.

- **Providers may prescribe drugs that they know are not stocked in the public facility but available at pvt chemists** - specific brands or fixed-dose combinations.
  - Providers prescribe a high number of drugs for each case of illness (2.90 drug products per visit). Majority of prescriptions are branded drugs & unnecessary to treat the condition.

- Most **common reasons cited by patients** for preferring pvt chemists -
  - better stock of drugs
  - variety of drugs
  - convenient hours (pvt chemists are open longer hours than public facilities)

Geographical co-location of private chemist shops around public facilities



Providers & chemist shops may collaborate through geographical co-location. 93% public hospitals have ~8 chemist shops & 58% public primary facilities have ~2 shops within 3 km radius.

Poor quality of care across the board

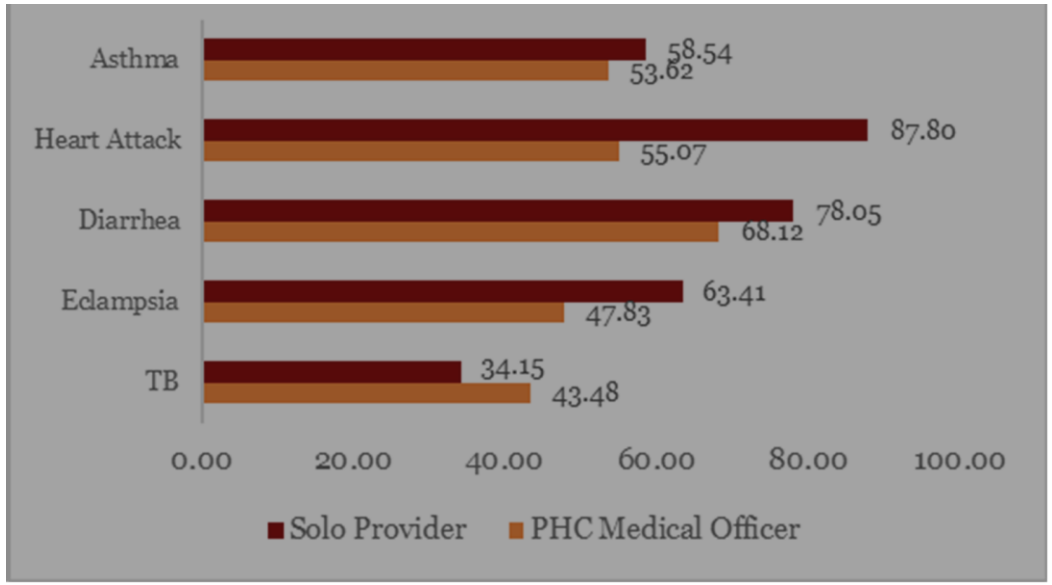
- **Incorrect diagnoses** - 58% diagnosed all 5 conditions correctly. Most cases wrongly diagnosed as a less serious illness (E.g., cold, fever for TB, headache for preeclampsia, acidity for heart attack)

- **Incorrect treatment** - Only 2.3% providers advised correct treatment. 42% prescribed only unnecessary (sometimes harmful) drugs/antibiotics – raising concerns of anti-microbial resistance (avg: >3 drugs)

Diagnose & treatment

Condition	Providers who diagnosed correctly (%)	Providers who gave the right treatment as per standard treatment guidelines (%)	Providers who gave at least one correct drug (%)	Providers who gave only unnecessary/ incorrect drugs (%)
Tuberculosis	40	6.82	N/A	91.90
Pre-eclampsia	53.64	0	52.54	39.98
Diarrhea	71.82	5.06	72.15	22.78
Heart Attack	67.27	0	55.41	25.68
Asthma	55.45	0	60.66	29.51

Diagnostic competence of public v/s private providers



Key message

- Incorrect/irrational prescriptions were equally prevalent among providers, irrespective of medical qualifications & public/private sectors
- Potential causes:
  - poor incentives, poor governance, poor regulation
  - Training: Only 10% of providers at PHCs were MBBS/MD, 51% had pharmacy/others degrees (unqualified to practice medicine), 35·6% AYUSH. Only 18.4% of all providers had any in-service training
  - 41% of PHC providers had last supervision ~6 months ago, 5% never had any supervisory visit

Poor patient safety culture in public hospitals & low levels of patient centeredness

- **Poor patient safety culture in public hospitals**
  - Survey of medical college hospitals (AIIMS), district hospitals and sub-divisional hospitals (N=2687 hospital staff), using Hospital Survey of Patient Safety Culture (HSOPS)
  - Adverse events and medical errors cause millions of deaths every year globally.
  - Almost no patient safety events (reports of a mistake that could harm a patient) reported in any of the hospitals surveyed.
  - <10% of hospital staff reported ever submitting a safety event report, compared to 45% among higher income countries.

- **Patient satisfaction for inpatient care**
  - Exit interviews of patients who had been hospitalized in medical college hospitals, district hospitals and sub-divisional hospitals (N=507 patients)
  - Very low satisfaction ratings were for:
    "*Understandings of care*" and "*post discharge planning*" (e.g., patient preferences being taken seriously, or doctors/nurses explaining the purpose of medications, how to take medicines, possible side-effects, guidance for at-home care). *"Hospital environment"* (cleanliness, privacy).
  - Large inequities in patient satisfaction:
    Patients with no formal education those from SC or ST groups received the lowest quality interpersonal treatment, dignity and respect (even within the same hospital, patients were treated unequally).

Low citizen satisfaction with the health system & significant inequity

- 56% - the health system needs major changes
- 33% the health system needs to be completely rebuilt
- 91% - the health system needs to be improved
- People reported higher satisfaction with physical access related aspects (E.g., provider location, hours of operation, availability. Lowest satisfaction reported for treatment expenses, especially at hospitals
- People with low income, low education, SC/STs, and those without insurance have lower satisfaction with the health system

Key Findings and Implications

- Financial risk protection is low; out-of-pocket spending on outpatient care and drugs are major drivers
- Large share of outpatient services happen in the private sector (with linked financial interest with public sector physicians)
- Inappropriate/excessive drug prescription is prevalent and quality of care is low in both public and private sectors
- Implications for UHC :
  - Current PM JAY does not cover outpatient services. In addition to poor FRP, can cause delayed care and also incentives to use hospital for simple health problems. How to cover them?
  - Value for money is low. Inappropriate prescription, mis-diagnosis, wrong treatment choices, have major implications on financial risk protection, health outcome. How to improve efficiency and quality of care?
- Systemic solutions are required: Financing is necessary but not sufficient. Service delivery needs to be improved simultaneously. Improving efficiency and quality usually meet less resistance when there is new money.

Value for Money

- Financial/purchasing power of NHA:
  - Selective contracting, including private providers (how to deal with informal providers?)
  - Pay by capitation with quality/performance rewards/penalties
  - Pay by capitation to a network of hospital+clinics to facilitate integrated/coordinated care. Hold hospitals accountable for improving primary care/outpatient care quality/efficiency
  - Establish essential/reimbursable drug list (will need to monitor out of list prescriptions)
- Leverage National Digital Health Mission, but technology/data alone does not lead to change, needs to integrate with governance and incentive systems
- Public sector:
  - Incentives and Accountability: tie promotion and bonus to quality, to how well hospitals help primary care improve quality in their district
  - Make having financial interest in pharmacies, labs illegal (US Sunshine law)